Written comments submitted to the Department of Health Care Services (DHCS) Regarding the Transfer of the Drug Medi-Cal Program to DHCS, effective July 1, 2012

Comments received August 31, 2011 through September 9, 2011

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On behalf of the California Association of Alcohol and Drug Program Executives (CAADPE) and at your request we are submitting the following comments in response to the Department of Health Care Services (DHCS) Draft Transition Plan to Transfer the Drug Medi-Cal Treatment Programs from the Department of Alcohol and Drug Programs (DADP) to the Department of Health Care Services (DHCS). in order to fulfill the requirements set forth in Assembly Bill I06.

To reiterate my comments made during the last Stakeholder Meeting on 8/22/l I please be aware of the following points:

- In general, CAADPE believes the initial draft plan is comprehensive and reasonable in nature and fairly captures stakeholder input to date from our perspective.

- We understand there are internal workgroups comprised of DHCS and DADP staff. We would like to suggest that the name of the workgroups and staff in these workgroups be produced for stakeholder dissemination.

- We understand DHCS is compiling a stakeholder distribution list; and it would be beneficial if the stakeholder list was shared.

- With regard to the program certification, we pointed out there are two types of certifications issues by DADP. One is specific to Drug Medi-Cal certification and the other relates to a voluntary program certification. Historically, we have advocated DADP should accept from providers their national accreditation, like the Joint Commission on Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF), in lieu of DADP program certification. It is not clear that the national accreditation can be accepted for the specific Drug Medi-Cal certification because it is specific to the Medi-Cal (Medicaid) Program. However it should be explored.

- With regard to the various workgroups we are requesting updates be shared with stakeholders on the work and progress of each.

- With regard to the reference of limited medications which can be used under the Drug Medi-Cal program, stakeholder input has already advocated for the need to expand the approved formulary to accommodate federally approved medications for craving reduction and relapse prevention. However, if the draft plan will highlight

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Buprenorphine as one of these medications we ask that it specifically mentions other medications as well, such as Vivitrol.

- With regard to the organizational structure and the draft organization chart provided, CAADPE wishes to reiterate its recommendation of two separate Deputy Directors. One Deputy Director for Substance Use Disorders (SUD) services and a second for mental health disorders services. CAADPE continues to oppose the current proposed structure of one Deputy Director with a Chief for substance abuse and a second Chief for mental health. One individual cannot fairly and adequately address the interest of both fields. By sheer size, mental health services, issues and priorities will take up a lion share of the attention from this single individual. Additionally, as stated we oppose use of the term "Behavioral Health" and strongly recommend the use of the term of Substance Use Disorders (SUD), as this is exactly what this is.

- Integrated Care- There was some discussion regarding Integrated Care and it was mentioned this was an item for later discussion. CAADPE strongly believes this is an immediate discussion that is needed now. A workgroup should be formed now to help address the integration of SUD services with the health and mental health systems. As you know SUD was left out of the states 1115 waiver, Bridge to Healthcare Reform. As such SUD is already well behind the efforts associated with integrated care under these plans. The bridge is weakened by the absence of SUD services. We need to immediately explore the regulatory and legislative barriers, delivery and systems barriers, workforce, training, education, capacity and systems development and more. .

- Drug Medi-Cal Cost Reports - With regard to Drug Medi-Cal cost reports and to echo comments made during the stakeholders meeting, the intent of prior recommendations is eliminate all cost reports. Cost reports by law are only required for four of the five authorized Drug Medi-Cal services; and it just so happens that the Narcotic Treatment Programs which represents the largest single service under Drug Medi-Cal is the one service not required to submit cost reports. . We agree with this and believe that cost reports should be eliminated for the remaining four services.

We appreciate your consideration of the points listed.

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The Drug Abuse Alternatives Center is the largest provider of Substance Use Disorder treatment services in Sonoma County and has over 20 years of experience in the provision of Drug Medi-Cal services to Outpatient, Perinatal Day Treatment and Methadone clients.

Our recommendations on the upcoming transfer of Drug Medi-Cal from ADP to DHCS are as follows:

· Maintain as much continuity in staffing as possible so that the knowledge of Drug Medi-Cal policies and procedures is not lost in the transfer including certification, billing, auditing, etc.

· Keep a state-wide rate setting methodology; don't leave it up to the counties.

· Be open to the changes necessary to improve the Drug Medi-Cal system so that it funds better treatment for the clients and is less onerous for the providers. Some suggestions are: allow two services to be billed in the same day (our clients often drive a distance to our clinics); allow home counseling for those who are ill; allow regular individual sessions above and beyond the limited individual sessions available now; include Buprenorphine as a narcotic replacement therapy; allow drug testing coverage; eliminate cost reports and other overly complicated procedures and forms such as the multiple billing override form.

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I would like there to continue to a California Department of Alcohol and Drugs (ADP).

If this is an impossibility I would like to suggest an Office of Alcohol and Drugs under the Department of Health Care Services. There is a staff experienced in the field of substance abuse.

I work in the Driving Under the Influence (DUI) field which has been administered by ADP. It is imperative that DUI be kept at the State level as there needs to be conformity throughout the 58 counties. An alternative would be that DUI programs would come under the Department of Motor Vehicles.

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What a sad day in California that all the years of effort with building Alcohol/Drug Programs Branch as an independent Department, can now be displaced with a signature. It makes little difference who "does the paper work" for Drug medi-cal, but I am totally opposed to the elimination of ADP as a stand alone and moving it under any other unrelated branch.

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How long will it be before everything is so streamlined that we totally lose perspective into the real need (people of California and their need for help)… and focus solely on the funding.

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The self populating subject line of your email worries me. It seems the only services you are concerned about are those that are related to Medi-Cal. As a Prevention practitioner for over 22 years, I know, and research shows, that at a minimum you save $7 for every $1 spent in prevention.

1.) What opportunities and/or benefits to counties...
1A.) I see a great opportunity for Counties to have less oversight than before in the area of fiscal responsibility for maintaining the 20% prevention set aside. Counties were only just beginning to really be held closely accountable for how and where their 20% Prevention Set Aside funds were spent. Without State oversight, and people who understand Prevention funding, Counties may seek the opportunity to chance expenditures that do not meet the criteria for Prevention Set Aside funding.

2.) What do you believe will be the greatest challenges...
2A.) Treatment has always been based on a fee for service model. This works for the treatment side because they work with individuals and at most, provide collateral services for the family. Prevention however, works with youth, individuals, communities, retailers, and problem environments just to name a few. Fee for service will not work for Prevention services especially in those counties where strong emphasis is placed on Youth Development, changing policy, changing environments and community norms and other long term, broad based efforts.

3.) What are the most important functions/activities/programs...
3A.) Data - California Outcomes Measurement Service for Prevention (Cal OMS pv), Technical Assistance, and fiscal oversight.

4.)Within which department or agency should these functions be located, and why?
4A.) Prevention uses a Public Health model. Public Health has had good success in other issues such as tobacco and immunizations. Many of the people who currently work in tobacco are currently partnered at the local level with those who work to prevention substance abuse.

5.) What are the most important functions...
5A.) Allow counties to determine the best mix of treatment services for their population,

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IE residential, HIV, perinatal, etc. Create a Memorandum of Understand (MOU) that directs Counties to partner locally with Public Health for Prevention Services. This would be an advantage for Public Health because many substance abuse prevention staff train and support youth in compliance checks for alcohol and they could do the same for tobacco. Alcohol and Other Drugs (AOD) Prevention staff know how to build coalitions and create collaborative, support youth in changing policy and help create healthier AOD free communities for people in Recovery to live and work.

6.) What other strategies should the Department of Alcohol and Drug Programs employ ...
6A.) Mandate that any funds that come to the Counties have a limit or cap placed on the amount and number of Administrative fees or "Indirect" that can be taken. This will allow Prevention to maximize the 20%. IE, State takes 5% to maintain Prevention functions, that is the cap and no other Indirect or Administrative costs can be taken from the 20%, funds must be spent on staff and services directly related to Prevention, no County Administrator salary or Mental Health Director salary.

7.) How can we best continue to involve stakeholders on an ongoing basis?
7A.) Allow and encourage Prevention staff in Counties to hold stakeholder meetings to provide feedback and promote communication.

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Thank you for providing a forum for providers and clients to offer their suggestions for managing the transitions that have been forced on the department. In the interest of providing comments from CRC Health Group, Inc., I have distilled the comments below from more detailed discussions with management, over the last year.

1. <u>Retain All Functions within California Department of Alcohol and Drug Programs (ADP) and keep them at the state level.</u>

Despite the fact that every provider, CRC included, has conflict with the department over one thing or another, CRC believes that ADP does a very good job, at all of its existing functions. We think it is a mistake to remove any of those operations from the department.

We also doubt that there are any savings to moving people around. A study 2 years ago determined that complete abolition of the department would save $1,000,000 in administrative salaries, at most. We believe that estimate was optimistic and that no cost efficiencies will be realized.

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If left to our own preferences, we think the department should be preserved in its current form.

2. <u>If ADP is to be broken up and moved to other departments, we recommend that:</u>

   a. The existing people and teams that do licensing and related activities be retained and kept together so that they can continue to perform the same licensing and regulatory services. This is recommended for licensing and regulation of residential programs, outpatient programs, and the Narcotic Treatment Program (NTP) clinics.

Having spent several decades, millions of dollars and thousands of hours training a cadre of competent people, who know and understand the field of alcohol and drug rehabilitation, it would be a terrible waste to lose those people to other functions or to replace them with people who had to start their training, anew.

   b. Retain all of the Needs Assessments, Outcomes Studies and Technical Assistance at the state level. Having a single, knowledgeable entity providing highly technical planning and specialized studies is an important function to the entire recovery community. ADP is perfectly suited to this task. The unit and the personnel within ADP that are responsible for this work should be kept intact and left to continue their work.

3. <u>If ADP is to be absorbed by another state department, we recommend that the realignment be to the Department of Health Care Services (DHCS).</u>

ADP works from a model of predominantly "non-medical recovery." While CRC believes that the model could be improved, with a limited amount of medical services, particularly at the beginning stages of recovery, we see no reason to move ADP's functions to a department that is primarily focused on doctors, hospitals and clinics, or other purely medical services. Such a move will concentrate the vision on a purely medical model.

Over a period of many decades, a mixed regimen of social model recovery, coupled with a small amount of medical assistance has proven the most effective and least costly treatment option. Moving ADP's function to a location where that balance is likely to shift would substantially raise the cost of services and reduce beneficial outcomes.

Again, CRC thanks you for offering us an opportunity to provide input to these very important decisions.